



*Your Partner for Voluntary Benefits*

**POLICY OWNER'S SERVICE REQUEST**

NAME OF EMPLOYEE \_\_\_\_\_ Phone # \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ SS # \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_  
Insurance Co \_\_\_\_\_ Policy Number(s) \_\_\_\_\_  
\*\*\*\*\*

**Change of Address as specified above**

**Bill directly at home address above as of** \_\_\_\_\_

**Change of Beneficiary**

I hereby revoke any and all prior beneficiary designations and existing settlement agreements, if any, and request the Company to change the beneficiary for the above referenced policy(ies) as follows:

**PRIMARY:** \_\_\_\_\_  
(Last Name, First Name, MI)

Relationship to Insured: \_\_\_\_\_ Age: \_\_\_\_\_

**CONTINGENT:** \_\_\_\_\_  
(Last Name, First Name, MI)

Relationship to Insured: \_\_\_\_\_ Age: \_\_\_\_\_

**Change of Name**

Insured From \_\_\_\_\_ To \_\_\_\_\_

Owner From \_\_\_\_\_ To \_\_\_\_\_

Beneficiary From \_\_\_\_\_ To \_\_\_\_\_

Reason for Change:

☐ Marriage ☐ Divorce ☐ Other (\_\_\_\_\_)

If other than marriage, divorce, or correction, attach copy of legal evidence.

**Request to Cancel**

I elect to terminate this policy effective \_\_\_\_\_, and agree that all rights, title and interest in this policy be assigned to the Company. Any cash surrender value (life insurance policies only) should be returned to me at the address above.

☐ Policy is enclosed

☐ Policy has been lost or destroyed

174 So. Freeport Rd, Ste 1C  
Freeport, ME 04032

**toll free**  
888-269-2744

**local**  
207-865-6244

**fax**  
207-865-4077

**e-mail**  
enroller@ebmi.net

I / We agree that my / our signature(s) below shall apply to each request which has been checked on this form and further agree that no request will become effective which is not checked

\_\_\_\_\_  
Owner's Signature Date

\_\_\_\_\_  
Witness Date